they do require treatment then what type, and to be delivered by whom? To my knowledge there is no generally agreed means of assessing the needs of patients with psychological disorders in general practice. In addition, there is no consensus about the types of interventions to be offered to such patients and no recognised agreement about the diagnostic labels to be used when referring to these patients.

I wonder if it is of value to reframe the problems at issue. Given the large range of psychiatric disorders seen in the community, a more productive approach might be to ask which of these require intervention, what sort of interventions should be given, who should be administering them and in what settings, and what the necessary skills and training requirements of the relevant staff are.

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Counselling has much to offer patients

EDITOR,—Simon Wessely's reactionary assault on counselling expresses a hostility that is widespread among psychiatrists.[1] Wessely urges the use of directive psychological treatment for specific syndromes that has been proved in comparative trials and is delivered by defined staff. He cites obsessive-compulsive and phobic disorders as such specific syndromes. He mentions anxiety and depression and sexual problems, but not bereavement or difficulties with relationships. He dismisses counselling for emotional problems (using quotation marks) as not amenable to empirical research.

Wessely claims that listening and empathic skills are part of the job description of every health professional. Unfortunately, this is not true, and some health professionals lack these skills. Almost universally, clinicians do not have sufficient time for empathic listening to patients' extended accounts. What time is available may not be best used in the search for specific syndromes. Of the 300 cases of psychiatric illness identified each year by a general practitioner (with a list of 2500 patients),[2] most will be cases of anxiety, depression, and tiredness, commonly compounded by relationship and social difficulties. Referral to a practice counsellor is a realistic option in a substantial number of cases. By contrast, assessment by a specialist secondary service followed by directive psychological treatment for panic disorder, depression, and the chronic fatigue syndrome (and also perhaps by family therapy and social skills training) could never be offered to more than a few patients.

It is, of course, right to question the efficacy of counselling in comparison with proved pharmacological and psychological treatments. The range of books on counselling reviewed in the issue of the *BMJ* that contains Wessely's article illustrates how general practice is coming to terms with these issues.[3] Organisations such as the British Association for Counselling and Relate (which helps people with relationship difficulties) are developing systems of training, accreditation, and supervision and have codes of ethics and practice. Wessely identifies himself as King Canute in the face of the sea of change in the role of counselling. He perhaps has something in common with the Anglo-Saxon king Ethelred "the Unready," so named for his lack of foresight in provoking the Danish conquest of England.

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Counsellors are seeing people with previously unmet needs

EDITOR,—Simon Wessely expresses justifiable concern about the limitation of the psychiatrist's role by recent changes.[1] There are, however, several points that I would challenge. He alleges that the retreat of psychiatry from the care of those with non-psychotic disorders has helped the growth in counselling services, but he does not cite evidence that counsellors are seeing patients who would otherwise have been seen by a member of a psychiatric team. There has long been a demand in primary care, which predates the changes, for help with the treatment of people with less severe problems—those who were often not appropriate for, or had not been helped by, referral to a psychiatrist. It is my impression that these people, with previously unmet needs, are those who are being seen by counsellors.

In asking for evidence of effectiveness Wessely assumes that counselling can be investigated as a treatment within a traditional quantitative paradigm. Orlinsky, discussing assumptions behind research hypotheses in psychotherapy, suggests that it can be viewed not only as treatment but also as education, reform, or redemption and that research questions and methodology should be informed by these ideas.[2] Such research requires qualitative approaches, and answers to questions about effectiveness will not be neat and clear.

It is no longer true that "much counselling is currently delivered by enthusiastic but unskilled and unsupervised staff," particularly not among counsellors funded by the NHS. Nationally agreed standards are being developed, with various professional organisations, such as the British Association for Counselling, already having their own accredited status.[3] In my area the minimum requirement for working as a counsellor in primary care on a scheme funded by the NHS is two years' training, membership of the British Association for Counselling, and regular monthly supervision. Many counsellors have, in addition, obtained postgraduate qualifications and are accredited (M Tinsley, personal communication) .

Wessely provides no references to support his statement that randomised controlled trials show that cognitive and other psychotherapeutic techniques can be effective for problems such as anxiety, depression, marital and sexual problems, abnormal grief, and so on. Nevertheless, these treatments may indeed be better for some people with these difficulties; no one would claim that counselling is right in every situation.

The debate on the place of counselling in the NHS must continue, and Wessely's challenging contribution is welcome. It seems to me, however, that his anger at what is happening in psychiatry has been turned on counselling in a way that is not entirely justifiable.

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Staff in mental health services need clearer guidelines

EDITOR,—As Simon Wessely describes,[1] recent government policy has sought to increase the influence of general practice on secondary services, which has had particular implications for providers of mental health services.[2] There has not been a definitive trial of the effectiveness of counselling in general practice,[3] but outcome studies are unlikely to be conclusive anyway.[4]

In this context, mere promotion of the idea that resources should be concentrated on long term mental illness is not good enough because of the temptation to interpret this directive in simplistic terms. The craving for certainty in definition has led to unequivocal statements that mental health services should treat long term severe mental illness and that primary care should deal with the lesser problems. This splitting of priorities between primary and mental health care has been unfortunate—a division that should not have been constructed when the aim is to have more fully integrated primary and secondary care and a primary care led NHS.

Clearly, the directive about concentration of resources is about relative rather than absolute priorities. It would be helpful if the Department of Health clarified this situation. Non-psychotic illness can be long term and severe, and severe mental illness may be less amenable to treatment than more minor disorders. It is not helpful if policy is sidelined into debates about the definition of mental illness, an issue that has been particularly controversial for psychiatry.[5]

Trusts need to provide services for people with mental health problems whether they have long term severe mental illness or not. Long term severe mental illness is core business, and care usually needs to be shared with the general practitioner, if only for the prescription of drugs. Non-core mental health problems should be prioritised on the basis of need and resources.

To avoid an unfair distribution of resources, general practitioner fundholders should not be treated any differently from non-fundholders. If changes are made explicit in contractual arrangements then general practitioners are likely to have more faith in the notion of a primary care led NHS and are entitled to expect resources to follow workload. Care managers should be encouraged to record unmet need because needs led assessment is unbalanced if details of only met need are compiled. Mental health promotion and other preventive work are a legitimate part of the work of trusts.

Reiteration of the above principles by the Department of Health might help to give clearer guidelines to staff in mental health services, leading to a renewed commitment and improving morale.

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